(11) (12) (12)

Nos. 93-1408, 93-1414 and 93-1415

Supreme Court, U.S.
FILED
NOV 16 1994
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*
Respondents.

MARIO CUOMO, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner,
v.
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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

23 pp

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BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

This brief *amicus curiae* of the American Federation of State County and Municipal Employees, AFL-CIO

("AFSCME") is filed with the written consent of the parties, as provided for in the Rules of this Court.

INTEREST OF THE *AMICUS CURIAE*

AFSCME is a nationwide labor organization with a current membership of approximately 1.3 million public employees. Several thousand AFSCME members are employed by public hospitals in the State of New York and are thus interested in the validity of the state statutes at issue here, which govern the cost of inpatient hospital services.

AFSCME's brief is joined by two AFSCME affiliates: New York City District Council 37, AFSCME, AFL-CIO ("District Council 37"); and State of New York, Civil Service Employees' Association, Local 1000, AFSCME, AFL-CIO ("CSEA"). District Council 37 represents New York City hospital employees, and CSEA represents New York State hospital employees.

INTRODUCTION AND SUMMARY OF ARGUMENT

The state scheme of regulating charges for hospital care that is at issue in this case is crafted to address both the obligations placed on hospitals to care for segments of the population at charges that are below what an unregulated market would generate and the complications inherent in providing inpatient hospital care insurance coverage to high risk individuals and groups. The essence of the solution adopted by the State is a system of differential hospital prices—and of differential government surcharges to those regulated prices—that is designed to spread the costs of providing inpatient hospital care to all segments of the population uniformly among private third-party payors, rather than to permit those costs to fall disproportionately on some payors because of the particular characteristics of the segment of the population that those payors serve.

A group health plan must necessarily choose from among various options for paying for health benefits pro-

vided to those covered by the plan. The decision below stands for the proposition that any state scheme for regulating hospital charges for inpatient care that alters the relative costs of those various options from what those costs would have been in an unregulated market "relate[s] to" health plans covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, and hence is preempted by ERISA § 514(a). On that decision, then, ERISA preemption serves to assure that ERISA plans can secure inpatient hospital services through a "free market" that is not "distorted" by state regulation of hospital charges.

It is our submission that ERISA does not force a state to choose a segmented "free market" hospital cost payment structure with its discriminatory inequities over a market structure that takes the benefit out of opportunistic activity by charging all private payors their fair portion of total hospital costs. ERISA, we submit, was not founded on the premise that health care providers and health insurers with whom plan sponsors and fiduciaries deal must be unregulated and that the providers and insurers must be free to set their charges and otherwise conduct their affairs so as to maximize the market options of ERISA health plans. ERISA does not in fact assume, dictate, regulate, or prefer any given means of providing, pricing, or insuring health care.

Contrary to the ruling below, then, ERISA cannot be read to deprive a state of the authority—which the States otherwise have as part of their traditional police powers—to regulate health care providers and insurers and to thereby structure the markets in which those entities function in the manner that the state determines will best achieve legitimate state regulatory objectives—and that does not interfere with any objective of ERISA.

As we show below, the general language of ERISA's preemption provision § 514(a), 29 U.S.C. § 1144(a), does not warrant such a federal intrusion into the tradi-

tional prerogatives of the States. The words "relate to any employee benefit plan" in § 514(a) were not intended to preempt state regulation that simply alters the relative costs of options that plan sponsors and fiduciaries remain free to adopt. This Court's decisions on the meaning of § 514(a) are entirely consistent with that understanding.

ARGUMENT

I

The state statutory provisions here at issue are part of a comprehensive scheme of regulation. We therefore begin by setting out the essentials of that scheme and the place of the challenged provisions within that scheme.

(a) The public policy of the State of New York, and of the United States, is to ensure that all segments of the population will be able to secure needed inpatient hospital care. Both the State and the Federal Government therefore treat hospitals as institutions imbued with a public purpose and subject both to certain responsibilities and to certain forms of price regulation. The Medicare and Medicaid programs finance hospital care—albeit on a severely discounted price basis established by government regulation—for a large part of the elderly population and the indigent population. Under certain circumstances, hospitals are, moreover, required to provide care to indigent patients not covered by Medicaid without receiving any payment of the costs associated with providing that care.

In addition, the practice of individuals in this society is to safeguard against the uncertainties and high costs associated with serious illness and accidents by securing insurance to provide for the costs of inpatient hospital care. There is a wide variation in the general population, from individual to individual, and among certain groupings of individuals, as to the risks of incurring significant inpatient hospital costs. If individuals and insurers were left to their own devices, individuals and groups with low risk characteristics would be able to secure hospitalization insurance at comparatively low premiums. And,

those with high risk characteristics would either be unable to secure such insurance or would be forced to pay higher premiums for that insurance.

(b) In New York, Blue Cross and Blue Shield ("the Blues"), both by practice and by virtue of regulatory obligation, have historically accepted the public burden of providing health insurance to otherwise uninsurable, high risk populations. *See* Joint Appendix ("JA") 161-62, 196-98, 218-19. The Blues have carried that burden through such practices as open enrollment and community rating of small, high risk groups. *Id.*

Since 1970, the State, pursuant to statute, has set the prices charged by hospitals to the Blues for inpatient hospital services at levels below those charged to other third-party payors. JA 148, 222. The State's action provided what was in practical terms a subsidy that enabled the Blues to continue to cover otherwise uninsurable, high risk populations and to provide insurance to other populations at competitive rates. This action meant that hospitals charged higher prices to other third-party payors to cover the costs of the services provided to the Blues' insureds—as well as of the services provided to Medicaid and Medicare patients at discounted rates. JA 148-49, 162.

(c) In the 1970s and early 1980s, some third-party payors were able to use their market power to obtain discounted hospital prices at or approaching the prices charged to the Blues. JA 149-50. This resulted in still more cost-shifting to the remaining third-party payors. JA 150. By 1982, the prices charged to all private third-party payors other than the Blues were on average 25% higher than the prices charged to the Blues, and in some areas of the State as much as 40% higher. JA 149.

In 1983, the State implemented a new statute setting a maximum rate differential between the Blues and other private third-party payors (except Health Maintenance Organizations, "HMOs") at 15%, and prohibiting hospitals from charging discounted prices to preferred private

third-party payors and not to all such payors. The practical result of this regime was a generally uniform 15% differential between the Blues and the other private third-party payors. JA 150.

(d) In 1988, New York replaced the 1983 scheme with a new comprehensive scheme, directly regulating the hospital charges for inpatient services to all third-party payors. The scheme establishes a base level price for every inpatient hospital procedure. Appendix to Petition for Writ of Certiorari ("Pet. App") 101-02. That is the price paid to the hospitals by Medicaid, the Blues, and HMOs. Pet. App. 101. By 1988, HMOs were in the same position as the Blues by reason of state regulation requiring similar open enrollment and community rating practices. JA 261-64.

The 1988 scheme establishes a second category of payors, including all commercial insurance companies and all self-insured groups that directly pay hospitals for inpatient hospital services provided to their beneficiaries. Prices for payors in this category are set at 13% above the base level. Pet. App. 102. This differential in the amounts payable to hospitals is a continuation of the State's effort to spread the costs of providing hospital care to high risk populations among the entire class of private third-party payors, and not just among those payors that have assumed the burden of providing that coverage. JA 153, 164-65, 228-29, 263-64.

In sum, with respect to the Blues and to HMOs, the 13% pricing differential serves to compensate for the competitive disadvantage those entities incur by virtue of their disproportionate coverage of high risk populations.

(e) In 1992, the State enacted additional provisions directed toward protecting the inpatient hospital services market. The State was confronted with a growing practice by commercial insurers that was causing further skewing of pricing in the health insurance market, and was again jeopardizing the ability of the Blues and HMOs to compete in that market. The problem, in brief,

was that, particularly in the late 1980s and early 1990s, private commercial insurers were actively "cherry picking" low risk groups, by offering those groups low premiums based on experience rating, thereby leaving the Blues, and the HMOs, the segment of the population that was becoming even more disproportionately comprised of high risk individuals. *See* JA 204-06, 232-33.

The State addressed this problem in two stages. The initial stage was to put into place a now-expired one-year surcharge of 11% on all inpatient hospital charges to patients covered by commercial insurers, but not to patients covered by other payors. Pet. App. 104. This surcharge served as a short-term measure to correct the market distortions resulting from commercial insurers experience-rating small low risk groups in order to garner the most attractive segments of the population. JA 206-07, 232-34.[1]

A long-term measure designed to address the "cherry picking" problem was put into effect by the State immediately upon the expiration of the one-year surcharge—April 1, 1993. This enactment requires that all health insurance policies in the State for individuals or for groups of 50 or fewer persons be issued on a community rated and open-enrollment basis, whether offered by commercial insurers or by the Blues. *See* N.Y. Ins. Law § 4317 (a) (McKinney Supp. 1994); JA 294.

A second aspect of the 1992 market reforms addressed the State's desire to control the spiraling costs of the Medicaid program by inducing HMOs—which utilize cost-saving managed-care techniques—to enroll an increased share of the Medicaid population. JA 175-77. The State sought to accomplish this purpose by imposing a variable surcharge on inpatient hospital services charged to HMOs, varying from 9% down to zero, depending upon each HMO's success in enrolling a defined target

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[1] Unlike the 13% pricing differential, this surcharge was paid to the State and thus served the additional purpose of providing revenue for the State. JA 284-85.

number of Medicaid eligible persons. Pet. App. 106-13; JA 175-77.[2]

II

Among those that provide group coverage for inpatient hospital costs and that arrange for the payment of such costs on behalf of members of the group are single employer, multi-employer, and employee organization health benefit plans that come within the ambit of ERISA. ERISA defines the term "employee welfare benefit plan" to include any plan established by an employer or employee organization "for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). The New York regulatory scheme here at issue has an impact on ERISA health benefit plans and that impact is what generates this ERISA preemption dispute. We therefore pause to describe that impact in some detail.

To begin, the state scheme does *not* regulate ERISA health benefit plans. The provisions at issue here do *not* impose any legal requirement on the sponsors or fiduciaries of such ERISA plans to take, or not to take, any particular actions. The impact of the scheme on ERISA plans—and the only impact—is not regulatory but economic. ERISA plans, like other third-party payors, are subject to the secondary effects of the state regulation of hospital charges. By reason of that regulation of entities that are not immune from state regulation under ERISA or any other federal law, ERISA plans face a different set of economic possibilities and opportunities than the plans would face in an unregulated market or a differently regulated market.

After the state regulation at issue here, as before, ERISA health plans continue to be free to choose from

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[2] This surcharge is also paid to the State and not to the hospitals. JA 175.

among a variety of health benefit packages for the plans' beneficiaries, and a variety of methods for providing those benefits. For example, in New York as elsewhere, the plans are entirely free to purchase health insurance from non-profit or for-profit insurance carriers; contract with health maintenance organizations or preferred provider groups; enter into arrangements that include some combination of the foregoing arrangements; or pay for the covered health services directly rather than through some intermediary. Pet. App. 6-7.

By definition, government regulation of a class of service providers aimed at restructuring their market will serve to alter the relative cost-based advantages of the providers. Here, because of the scheme at issue, certain mechanisms for paying for inpatient hospital services provided to ERISA plan beneficiaries may well have become more or less attractive than in a market that had not been restructured. Thus, absent the restructuring, the Blues might not have been able to offer to ERISA plans a package as advantageous to the plans as can be offered by the Blues after the restructuring. By the same token, other mechanisms for paying for inpatient hospital services—commercial insurance or self-funding—may have become relatively less advantageous from the plans' standpoint, at least on a cost basis.

These changes in the relative advantages of the various payment mechanisms are the direct consequence of the State's restructuring the market so that all private payors equitably share the costs of providing inpatient hospital care to all segments of the State's population, including the high risk and indigent populations, rather than permitting those costs to fall disproportionately on some payors because of the particular characteristics of the segment of the population that they serve.

By reason of these market adjustments, those payors that cover a disproportionately high proportion of low risk segments of the population will have to pay more for inpatient hospital services than the amount that they

would have paid in a market predicated on the risk characteristics of each particular segment of the population and on the actual costs of the hospital care provided to each covered individual. And, of course, the opposite would be true for those payors that cover a disproportionately high proportion of high risk segments of the population.

III

There is room to dispute the wisdom and the efficacy of the State's efforts to regulate hospital charges to prevent the inpatient hospital services market and the health insurance market from becoming segmented and to provide that the moneys paid by all insured patients cover the shortfall caused by discounts to Medicare and Medicaid and by the provision of services to indigent patients not covered by Medicaid.

But there is no room to dispute that the State is, indeed, regulating hospital charges and that the entirety of the effect on ERISA health benefit plans is the *economic* effect of this regulation. The question here then is whether ERISA precludes a state from engaging in such regulation of hospital charges—or, more technically, whether ERISA exempts ERISA health plans from having to pay for patient care provided to their beneficiaries on a basis that charges them their share of total hospital costs as established through such a regulated market.

(a) ERISA § 514(a)—the ERISA preemption provision—states that "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has made it plain that, as the statutory language indicates, ERISA preemption is broad. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) ("A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."). But neither

the statutory words nor this Court's decisions interpreting those words stand for the proposition that ERISA preemption is limitless. The term "a law that 'relate[s] to' a party" is not a term of art that is inevitably equated with, or inevitably encompasses, every "state regulation of a third person that has an economic effect on that party." And, it is our position here that a state law regulating hospital charges, and doing so on a rational basis that does not single out ERISA plans, is *not* a state law that "relate[s] to" ERISA plans merely because the law generates secondary economic effects on all private payors including ERISA plans.

On a certain world view everything is related to everything else. Whatever the merit of that view, if the "relate to" language of § 514(a) were read in that way, ERISA plans would literally be placed above all the civil law of the states in which they operate. Such a reading would be extraordinary. We know of no context in which Congress has ever taken such a step with respect to any private entity. To ascribe such an intention to Congress from the general words "relate to," and without a more specific and express statement of such an intention, would run counter to the most basic understandings of the relationship between the Federal Government and the States. "[W]e start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Hillsborough County v. Automated Medical Labs., Inc.* 471 U.S. 707, 715 (1985) (internal quotations omitted). *Accord, e.g., Cipollone v. Liggett Group, Inc.*, —— U.S. ——, 112 S. Ct. 2608, 2617-18 (1992).

That being so, this Court has already made it clear that "relate to" in § 514(a) does not sweep away the run of state law. In *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), this Court recognized that § 514(a) does not preempt a variety of state law claims brought directly against ERISA plans:

> ERISA plans may be sued in a second type of civil action, as well. These cases—lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan—are relatively commonplace. Petitioners and the United States (appearing here as *amicus curiae*) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA § 514(a). [*Id.* at 833 (footnote omitted).]

The state law actions described as not "relate[d] to" ERISA plans in this passage operate directly on such plans. Those actions are predicated on legal obligations imposed on the plans by state law, and may result in the imposition on the plans of state law remedies. The state scheme at issue here has *no* such relational nexus to ERISA plans. As we have shown the state scheme regulates hospital prices and imposes surcharges on commercial insurers and HMOs. The sum and substance of the state regulations' relation to ERISA plans is to restructure the market in which ERISA plans, among others, deal in a manner that has an economic impact on those plans; that impact is one that alters the relative costs of the various options that are available to ERISA plans for paying for the health benefits of plan beneficiaries from what those costs would have been in an unregulated market. And, this economic consequence of the state scheme affects ERISA health plans in precisely the same way as non-ERISA health plans.

So far as we are aware, in the "normal sense of the phrase," *Shaw*, 463 U.S. at 97, a law regulating A in a manner that structures what A can offer on the market and thereby affecting B, C and D who are on the other side of that market is not a law that "relate[s] to" B, C and D. In our jurisprudence, B, C and D have no expectation, much less a right, to participate in any particular market or to deal with market participants who are free of regulatory constraints. That general understanding applies with full force to a market structured by health care regulations.

Health care providers have long been heavily regulated by the States. State licensing provisions, tax provisions, staffing requirements, patient care protocols, malpractice standards and remedies, health care subsidies and scores of other forms of state regulation are major determinants of the types of inpatient hospital care that is available on the market in any state and of the cost of that care. The scheme of regulation here at issue is well within the scope of the traditional state regulation of health care. As we have shown, the State has sought, through regulation of hospital charges, to spread the costs of providing inpatient hospital care to all segments of the population uniformly among the various types of private third-party payors. Like the other forms of state regulation of the provision of hospital care, the regulation of hospital charges here is a classic exercise of the police power to achieve a basic social good. *See, e.g., Pennell v. City of San Jose*, 485 U.S. 1, 11-14 (1988); *Fisher v. City of Berkeley*, 475 U.S. 260, 264 (1986); *Nebbia v. New York*, 291 U.S. 502 (1934); *Munn v. Illinois*, 94 U.S. 113 (1877).

State regulation of hospital care—and the attendant effects of that regulation on the costs of hospital care—was prevalent when ERISA was enacted, as it is today. Yet there is nothing in ERISA's language or its legislative history evincing an affirmative congressional intent to federalize the regulation of the provision of hospital care in all its manifest complexity. Nor is there any express indication in ERISA of a congressional intent to end state regulation of hospital care and to replace it with a federally mandated regulatory void—or, in more precise terms, to entitle ERISA plans to secure hospital services in an unregulated market.

The only possible exception to the foregoing assertions is the "relate to" language of § 514(a), standing alone. We submit that those words cannot possibly bear that weight. It is one thing to say, as this Court has said, that in the interests of uniformity Congress intended to prevent the States from directly or indirectly imposing

legal or administrative obligations on ERISA plans. *See infra* pp. 14-18. That, after all, is consistent with the Act's purpose in setting a national legal framework for employee benefit plans, including plans that operate on a multi-state basis. It is quite another to say that Congress, without a whisper to so indicate, intended to oust the States from regulating health care providers in any manner that affects—or substantially affects—the opportunities of ERISA plans. That would amount to a congressional intention to create a right of ERISA plans to procure hospital services for plan beneficiaries in a uniform unregulated market. It would be folly to attribute to Congress the silent desire to create a nationwide health care "free market" for ERISA plans. There has never been such a market and it is all but impossible to conceptualize how such a market could be created in this society or how it could function.

Even without the kinds of state law provisions at issue here, the markets for procuring health services available to ERISA health plans will differ from state to state depending upon a multitude of variables respecting the structure of health care delivery systems within each state, demographic and geographic considerations, variations in cost structure in the health care delivery systems and in the insurance systems within each state, and so on. Multi-state ERISA health plans must take these market differences from state to state into account in determining what kind of payment system to adopt or maintain. The provisions at issue here do no more than affect the relative cost structure in one of the markets ERISA plan sponsors and fiduciaries must evaluate in exercising their discretion to adopt a payment system suited to their respective plans.

(b) While the precise issue presented here is one of first impression, this Court's cases construing the meaning of "relate to" in § 514(a) are entirely consistent with the conclusion that the state statutes at issue here are not preempted by ERISA. This Court's decisions giving that language a broad sweep have been generated by

state laws that were premised on the existence of ERISA plans or that sought, directly or indirectly, to impose a *legal requirement* on ERISA plans—*viz.*, that sought to require those plans to take, or not to take, a certain action. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (provision in New Jersey workers' compensation statute "relates to" ERISA pension plans because it would prohibit plans from employing "one method for calculating pension benefits—integration—that is permitted by federal law"); *Shaw*, 463 U.S. at 97 ("the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans"); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (Massachusetts insurance law provision "bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (state common law tort and contract actions "relate to" ERISA plans to the extent that they are premised on the failure of an ERISA plan to pay benefits); *Mackey*, 486 U.S. at 829 ("The Georgia statute at issue here expressly refers to—indeed, solely applies to—ERISA employee benefit plans."); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (Pennsylvania antisubrogation law relates to ERISA plans because it "prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party."); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) ("Texas cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan."); *District of Columbia v. Greater Washington Bd. of Trade*, —— U.S. ——, 113 S. Ct. 580, 583 (1992) (provision in workers' compensation statute "relate[s] to" ERISA plans where the obligations it imposes on employers depends entirely on whether the employer has chosen to create and maintain an ERISA plan).

In *Shaw*, the Court quoted liberally from floor statements made by three members of Congress who managed the legislation. Those floor statements describe the final, conference version of § 514(a) as preempting state laws that, directly or indirectly, *impose legal requirements* for the operation of ERISA plans.

For example, Representative Dent, in the passage quoted in *Shaw*, stressed that the conference version of § 514(a) was intended to assure "the reservation to Federal authority [of] sole power to *regulate* the field of employee benefit plans . . . by eliminating the threat of conflicting and inconsistent State and local *regulation*." 463 U.S. at 99, quoting 120 Cong. Rec. 29,197 (1974) (emphasis supplied). Similarly, Senator Williams referred to an intention "to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local *regulation*." *Id.*, quoting 120 Cong. Rec. at 29,933 (1974) (emphasis supplied). And, Senator Javits said that § 514(a) addresses "the desirability of further *regulation*—at either the State or Federal level." *Id.* at 99 n.20, quoting 120 Cong. Rec. 29,942 (1974) (emphasis supplied). *See also* Senator Javits' comment, in a colloquy not quoted in *Shaw*, that with respect to plans providing prepaid legal services "it is intended that State regulation—but not bar association ethical rules, guidelines or disciplinary actions" be preempted, Legislative History of ERISA, 4789 (Sen. Labor Sub. Print 1976); *id.* ("the State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan").

Subsequently, in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987), the Court characterized these floor statements as "clearly disclos[ing] the problem that the preemption provision was intended to address":

> These statements reflect recognition of the administrative realities of employee benefit plans. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such

> a system is difficult to achieve, however, if a benefit plan is subject to different *regulatory requirements* in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others. . . .
>
> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation. . . . *Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.* [482 U.S. at 9-11 (emphasis supplied).]

See also id. at 10-11 (reviewing the earlier cases in which ERISA preemption was found, and concluding that "[w]e have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's *administrative scheme* would be subject to conflicting *requirements*") (emphasis supplied).

Consistent with these legislative materials, this Court in *Ingersoll-Rand* stated the rationale for ERISA pre-emption as follows:

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government [498 U.S. at 142.]

That rationale for preemption defines the outer limits of the "relate to" concept in § 514(a). State laws that impose no "requirements," directly or indirectly, on ERISA plans are outside those limits. By definition such state laws cannot impose requirements contrary to the

requirements of ERISA or threaten ERISA plans with the possibility of being subject to different or conflicting requirements in other states.[3]

CONCLUSION

For the foregoing reasons, the decision and judgment of the United States Court of Appeals for the Second Circuit in this case should be reversed.

Respectfully submitted,

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[3] If, contrary to what we have argued, New York's statutory scheme is found to "relate to" ERISA plans within the meaning of ERISA § 514(a), the Court would then have to consider the second question presented. That question is whether the New York statutory scheme is saved from ERISA preemption by ERISA § 514(b)(2)(A), which provides, in pertinent part, that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*." 29 U.S.C. § 1144(b)(2)(A) (emphasis supplied). Given the substance and the purpose of the New York statutory scheme at issue here, *see supra* pp. 4-8, it is our submission that the New York scheme is one that "regulates insurance" within the plain "common sense" meaning of that term. *See Metropolitan Life*, 471 U.S. at 740; *Pilot Life*, 481 U.S. at 48. We thus fully embrace the position of petitioners and the United States on this issue.